	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE COMPL	
AND FLAN	OF CORRECTION	15E245	A. BUII		00	06/21/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	R			86TH ST		
ST AUGU	JSTINE HOME FO	R THE AGED		INDIAN	APOLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
F0000	REGULITORI	CESC IDENTIFY THIS IN ORDER THON	+	1710			DATE
	This visit was t	for a Recertification and e Survey.	F00	00			
	Survey dates: 2012	June 18, 19, 20 & 21,					
	Facility numbe Provider numb AIM number:						
	Survey team: Diana Zgonc, I Connie Landm Lora Brettnach Christi Davidso Census bed ty NF: Residential: Total: Census payor Medicaid: Other:	an, RN ner, RN pe: 40 24 64 type: 34 30					
	Total: Residential sa	•					
		ncies reflect state n accordance with 410					
	Quality review	completed on June 27,					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15E245	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 06/2	E SURVEY PLETED 1/2012		
	PROVIDER OR SUPPLIER JSTINE HOME FOR THE AGED	STREET ADDRESS, CITY, STATE, ZIP CODE 2345 W 86TH ST INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	2012 by Bev Faulkner, RN						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RZ2E11

Facility ID: 000389

If continuation sheet

Page 2 of 24

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15E245	A. BUIL B. WING			06/21/	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				/ 86TH ST		
ST AUGL	JSTINE HOME FOR	R THE AGED			APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0224	483.13(c)						
SS=D	PROHIBIT						
		T/NEGLECT/MISAPPROPRI					
	ATN	dayalan and implement					
		develop and implement nd procedures that prohibit					
		glect, and abuse of					
		sappropriation of resident					
	property.	The second second					
	Based on interv	view and record	F02	24	To enable all to realize the		06/25/2012
	review, the faci	lity failed to ensure a			importance of seeing that		
	resident was fro	•			residents are free of any		
		on of property in that a			misappropriation of funds the	and .	
		crucifix went missing			following policy was adopted a each employee will be required		
	•	covered for 1 of 3			sign this policy. An inventory	u to	
		met the criteria for			sheet will be filled out upon		
					admission and any time the		
	missing proper	ty. (Resident #2)			resident acquires something.		
					new. The inventory sheet wou		
	Findings includ	e:			state the value of any jewelry;		
					the the family chooses to leave in the resident's possession.	e It	
	The record for	Resident #2 was			Sometimes it may be well to b	HV.	
	reviewed on 06	3/19/12 at 2:37 p.m.			an in-expensive piece of jewel	-	
					that resembles the more	,	
	Diagnoses inclu	uded, but were not			expensive one. When a reside	ent	
	limited to multip				is not wearing an expensive pi		
	•	nd vitamin deficiency.			of jewelry it should be locked i	n a	
	00100p0.00.0				secure box. Our policy does		
	The most recer	nt annual Minimum			cover both property and funds The in-service director will kee		
] assessment, dated			running log of all who have sig	•	
	-	ed the resident was a			this adedenum. Anyone failing		
	· · · · · · · · · · · · · · · · · · ·				keep this policy will have		
	•	sible 15 on the Brief			disciplinary procedures up to a	and	
		ental Status [BIMS]			including dismissal. The		
	•	ion. A BIMS of 15			Administrator will report the		
		esident was cognitively			incident to the state and the police. The Administrator will		
	intact.				keep a file on all concerns		
					reported to her and what she	did	
			l		'		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RZ2E11 Facility ID: 000389

If continuation sheet Page 3 of 24

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE SI	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	ILDING	00	COMPLE	TED
		15E245	B. WIN			06/21/2	012
			D. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER			86TH ST		
ST AUGI	USTINE HOME FC	OR THE AGED			APOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	During an inte	rview on 6/19/12 at			to correct them. An in-service	with	
	9:04 a.m., Res	sident #2 indicated she			the staff at change of shift will		
	was missing a gold crucifix. Resident				explain the importance of following this policy. The Siste	ron	
	#2 could not re	emember the exact time			the unit will be responsible for		
	frame it went i	missing. Resident #2			conducting the investigation. T		
		crucifix was not found			DON or another individual		
	and it was irre				assigned by the administrator		
		piacoubic.			may help.		
	A nurses note	, dated 10/18/11 at					
		dicated, "Called					
		set. Stated she had an					
		necklace on her					
	_						
		p [sign for and] missing					
		e note indicated charge					
		and POA [power of					
	attorney] notifi	ied.					
	A social service	ce progress note, dated					
		40 p.m., indicated, "This					
		en away on vacation					
		c - Told by [name of Unit					
		[related to] loss of this					
		-					
		cklace [sign for with]					
	<u>'</u>	nt '18 K [carat] gold!'					
	and has had it	•					
		iccess finding necklace,					
	<u>-</u>	sident] had left in her					
	room on a she						
	bookcaselef	t necklace for abt					
	[about] 2 hr [h	our] time and went back					
	to room from a	activities - necklace					
	gone"						
		ce progress note, dated					
	10/25/11 and	not timed, indicated,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RZ2E11

Facility ID: 000389

If continuation sheet Page 4 of 24

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15E245	B. WIN	G		06/21/	2012
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					86TH ST		
STAUG	USTINE HOME FC	R THE AGED		INDIAN	APOLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
		Res. friendwho					
		Resident's version of					
		rredstates she is					
		it very hard'no hope					
	_	restigated [sign for and] out [sign for no] success					
	· •	vay or if anyone,					
		r this lossof course					
	•	n for and] locks door					
		" The social service					
	_	the administrator was					
	aware.	are darimined ater was					
	A social service	e progress note, dated					
		00 p.m., indicated,					
		n - states she's not					
	'forgotten' nec	klace loss, but 'life goes					
	on'"	-					
	A social service	e progress note, dated					
	11/29/11 and	not timed, indicated,					
	"Shebroug	ht up for discussion the					
	recent loss of	a gold necklace, which					
		e investigated and					
	,	lministrator and others					
	involved"						
	_	rview on 6/19/12 at					
	•	investigation regarding					
	_	ucifix was requested					
	from the Direc	tor of Nursing (DoN).					
	During an inte	niow on 6/20/42 of					
	_	rview on 6/20/12 at					
		Unit Manager indicated					
	a report was fi	led for the missing					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RZ2E11

Facility ID: 000389

If continuation sheet Page 5 of 24

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15E245	B. WIN			06/21/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		2345 W	86TH ST		
ST AUGI	JSTINE HOME FO	R THE AGED			APOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	†	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	crucifix.						
	On 6/20/12 at	9:45 a.m., a report filed					
	by the Unit Manager regarding the						
	1 -	x, dated 10/18/11, was					
	presented by t						
	procented by	5014.					
	A type written	report, dated 10/18/11					
		and provided by the					
		•					
		d Resident #2 reported					
	_	old crucifix and chain					
	_	report indicated,					
	"reported sh	e leaves it on the book					
	case shelf who	enever she removes it					
	and this is only	y when out of the room					
		d bathWhen she					
	returned to he						
		oticed that it was not in					
	1	on the bookcase					
	•	vere searched and it					
		foundrelated the					
	situation to [na						
	Administrator]	····"					
	_	rview on 6/20/12 at					
	12:41 p.m., the	e Unit Manager					
	indicated she	was not aware if a					
	police report h	ad been filed or if the					
		gency had been					
	notified. She						
		would make that					
	decision.	Todia make triat					
	uccioion.						
	During an inte	nious with the DeN en					
	_	rview with the DoN on					
	6/20/12 at 12:	45 p.m., she indicated					

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Event ID: RZ2E11

Facility ID: 000389

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	
		15E245	B. WING			06/21/	2012
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					86TH ST		
ST AUG	USTINE HOME FC	R THE AGED		INDIAN	APOLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
		rned from retreat and					
		missing crucifix, the					
	resident was asked the value of the crucifix, and a reimbursement was						
	•	DoN indicated the					
		ne POA declined the					
		it indicating it was from					
		ry and was not					
	replaceable.	y and was not					
	Topiaocabic.						
	During an inte	rview on 6/20/12 at					
	_	Administrator indicated					
		ucifix was not reported					
	_	r the state survey					
	· ·	Administrator indicated					
	•	picion a staff member, a					
		gold crucifix, and the					
	· ·	terminated for other					
	performance is	ssues. The					
	Administrator	indicated the resident					
	was "distraugh	nt" over the loss.					
	A facility policy	y, titled, "Abuse					
	Prohibition, Re	eporting and					
	Investigation of	of Resident Abuse,					
	Neglect and M	listreatment," dated					
	•	ovided by the DoN on					
		0 a.m., indicated,					
	•	dentis entitled to					
		irteous treatment. The					
	· ·	t tolerate rude,					
	_	abusive behavior					
		dent or any other					
		of a Resident. For					
	purposes of th	is policy, 'mistreatment'					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RZ2E11

Facility ID: 000389

If continuation sheet Page 7 of 24

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15E245	A. BUILDING B. WING	00	— COMF	ESURVEY LETED 1/2012
	PROVIDER OR SUPPLIER		2345 W	ADDRESS, CITY, STATE, ZIF / 86TH ST APOLIS, IN 46260	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Sappropriation of Derty"	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	3.1-28(a)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RZ2E11

Facility ID: 000389

If continuation sheet

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E245	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2012
			B. WING	ADDRESS CITY STATE SID COSS	<u> </u>
NAME OF P	ROVIDER OR SUPPLIER	3		ADDRESS, CITY, STATE, ZIP CODE	
CT ALICI	JSTINE HOME FOR	DITUE ACED		/ 86TH ST	
ST AUGU	JSTINE HOME FOR	R THE AGED	INDIAN	IAPOLIS, IN 46260	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)			
SS=D	INVESTIGATE/F				
	ALLEGATIONS/				
		not employ individuals who			
		d guilty of abusing,			
		istreating residents by a court			
		ad a finding entered into the			
		registry concerning abuse, tment of residents or			
	-	of their property; and report			
		t has of actions by a court of			
		mployee, which would			
	-	s for service as a nurse aide			
	or other facility s	taff to the State nurse aide			
	registry or licens	ing authorities.			
	•	ensure that all alleged			
		ng mistreatment, neglect, or			
	_	injuries of unknown source			
		ation of resident property are ately to the administrator of			
		o other officials in accordance			
	•	rough established			
		uding to the State survey and			
	certification ager	-			
	· ·	·			
	The facility must	have evidence that all			
	alleged violation	s are thoroughly investigated,			
	•	nt further potential abuse			
	while the investion	gation is in progress.			
	The	Lipypotiantings must be			
		l investigations must be			
	•	dministrator or his esentative and to other			
	-	dance with State law			
		State survey and certification			
		working days of the incident,			
		d violation is verified			
		ective action must be taken.			
		view and record	F0225	All staff and residents will be	07/09/2012
		ility failed to report an		informed that any time a staff	
	. 57,517, 110 100	anoa to roport arr		member is short or cranky wit	h a 📗

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Event ID: RZ2E11

Facility ID: 000389

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPLETED
		15E245	B. WIN			06/21/2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	8			/ 86TH ST	
ST AUGI	JSTINE HOME FOI	R THE AGED			APOLIS, IN 46260	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	· 	(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	allegation of ar	n employee being			resident or other staff member	
	-	esident and failed to			this should be reported to the	
	report an alleg				Sister on the unit who will	
	misappropriation of a gold crucifix to				immediately inform the	
		_			Administrator. The Administra	
		y agency for 2 of 3			with the assistance of the Sister on the unit and the DON will	CI
	I -	dents reviewed. (#2,			collect information from the	
	#41)				involved parties and report to	the
					state within 24 hours if an abu	se
	Findings includ	le:			did occur. Disciplinary measu	
					will be taken up to and includir	•
	1. The record	for Resident #2 was			termination. An employee will	
	reviewed on 06/19/12 at 2:37 p.m.				suspended until the investigati is completed. When gathering	
					information the resident's total	_
	Diagnoses incl	uded, but were not			medical history will be reviewe	
	limited to multi	ple sclerosis,			At least prior to every care	
		nd vitamin deficiency.			conference the resident will be	
		•			interviewed as to how the staff	
	The most recei	nt annual Minimum			treating them. Each employed will sign the policy reminding	
		assessment, dated			them of respect. The resident	s
	_	ed the resident was a			will be given a notice stating th	
	•	sible 15 on the Brief			any time an aide is cranky with	
		ental Status [BIMS]			them or does not answer their	
					to tell the Sister on their unit. 1	
	_	tion which indicated the			employee handbook states tha	
	resident was c	ognitively intact.			an employee can be suspende with or without pay for up to th	
	Duning a size instant	niow on C/40/40 -+			days.	
		view on 6/19/12 at				
	,	ident #2 indicated she				
	_	gold crucifix. Resident				
		member the exact time				
		nissing. Resident #2				
	indicated the c	rucifix was not found				
	and it was irrep	olaceable.				
	A nurses note,	dated 10/18/11 at				
	10:00 p.m., ind	licated, "Called				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RZ2E11

Facility ID: 000389

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		15E245	B. WIN			06/21/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			86TH ST		
ST AUGU	JSTINE HOME FOI	R THE AGED			APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		set. Stated she had an					
	18 carat gold n	ecklace on her					
	bookshelf at 2 p [sign for and] missing						
	by 4 p" The	note indicated charge					
	nurse notified a	and POA [power of					
	attorney] notified.						
	A social service	e progress note, dated					
		10 p.m., indicated, "This					
		n away on vacation					
		- Told by [name of Unit					
		related to] loss of this					
		klace [sign for with]					
		nt '18 K [carat] gold!'					
	and has had it						
		ccess finding necklace,					
		ident] had left in her					
	room on a she						
		necklace for abt					
	[about] 2 hr [ho	our] time and went back					
	to room from a	ctivities - necklace					
	gone"						
	During an inter	view on 6/19/12 at					
	4:30 p.m., the i	investigation regarding					
	•	ıcifix was requested					
	_	or of Nursing (DoN).					
		(= 0.1).					
	During an inter	view on 6/20/12 at					
	_	Unit Manager indicated					
		was filed for the					
	missing crucifix	K.					
	On 6/00/40 =±/	0.45					
		9:45 a.m., a facility					
	report filed by f	the Unit Manager					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RZ2E11

Facility ID: 000389

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STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	S X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E245	(X2) MULTIPLE CO A. BUILDING B. WING	00 	COM	TE SURVEY MPLETED 21/2012
NAME OF PROVIDER OR SUPP ST AUGUSTINE HOME		2345 W	ADDRESS, CITY, STATE, ZIP / 86TH ST APOLIS, IN 46260	CODE	
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PERCEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
1 1 5	e missing crucifix, dated as presented by the DoN.				
and not time DoN, indicar an 18 carat missing. The "reported case shelf wand this is of for a schedureturned to limmediately its usual plashelfareas					
12:41 p.m., indicated shipolice reportstate survey notified. Shipadministrate decision. During an in 6/20/12 at 1 when she reports the survey notified and shipped sh	terview on 6/20/12 at the Unit Manager e was not aware if a t had been filed or if the agency had been e indicated the or would make that terview with the DoN on 2:45 p.m., she indicated the asked the value of the				

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Event ID: RZ2E11

Facility ID: 000389

If continuation sheet

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		15E245	A. BUILD: B. WING	ING		06/21/2012	
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		2345 W	86TH ST		
ST AUGI	USTINE HOME FO	R THE AGED		INDIAN	APOLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		REFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETI DATE	ON
		DoN indicated the				5.112	
		ne POA declined the					
	reimbursemen	t indicating it was from					
	another countr	ry and was not					
	replaceable.						
	_	rview on 6/20/12 at					
		Administrator indicated ucifix was not reported					
	_	the state survey					
	•	Administrator indicated					
	•	picion a staff member, a					
		gold crucifix, and the					
	CNA was later	terminated for other					
	performance is	ssues. The					
	Administrator i	ndicated the resident					
	was "distraugh	t" over the loss.					
	2. The record	for Resident #41 was					
		/19/12 at 3:39 p.m.					
	. •	luded, but were not					
		rtension, coronary					
	chronic airway	s, osteoporosis, and					
	Cilionic all way	obstruction.					
	The most rece	nt annual Minimum					
		S) assessment, dated					
	,	ed Resident #41 was a					
	15 out of a pos	ssible 15 on the BIMS					
	_	tion which indicated					
	Resident #41 v	was cognitively intact.					
	During an inter	rview on 6/18/12 at					
	_	esident #41 answered					

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	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE COMPL	ETED
		15E245	B. WING	G		06/21/	2012
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE 86TH ST		
ST AUGI	JSTINE HOME FOR	R THE AGED		INDIAN	APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	been rude to you indicated some and bathing the because they a During an inter-	ed, "Has staff yelled or ou?" Resident #41 times during dressing CNA's were "cranky re understaffed." view on 06/19/12 at #2 indicated Resident					
	#41 had never with the CNA's LPN #2 indicate complaints had indicated, "You everyone is." L Resident #41 re and was on a T bath schedule.	indicated discontent that worked with her. ed no other resident been voiced. LPN #2 see how friendly PN #2 indicated eceived a bath today uesday and Friday LPN #2 indicated equired assistance with					
	3:58 p.m., CNA Resident #41 h day shift CNA's the way she wa CNA #3 indicat indicated the C CNA #3 indicat	view on 6/19/12 at a #3 indicated that ad indicated to her the do not care for her ants to be cared for. ed Resident #41 NA's are "mean." ed she had informed dent #41's care					
	4:04 P.m., LPN not aware of Re	view on 6/19/12 at #4 indicated she was esident #41's indicated she would					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL		(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPL	
		15E245	B. WING		06/21/	ZU Z
NAME OF I	PROVIDER OR SUPPLIEF	R		DRESS, CITY, STATE, ZIP CODE STH ST		
ST AUGI	JSTINE HOME FO	R THE AGED		POLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	 PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		I or the Unit Manager if	TAG			DATE
		ware of a resident care				
		indicated she could not				
		sharing information				
		sident #41. LPN #4				
		dent #41 was always				
		hout complaints.				
	During an inter	view on 6/19/12 at				
	_	DoN indicated she was				
	not aware of a	ny care concerns				
	voiced from Re	esident #41. She				
	indicated "that	really puzzles me."				
	During an inter	view on 6/20/12 at				
	8:32 a.m., the	DoN indicated after				
		ne concerns from				
		these concerns were				
		#3 in December 2011,				
		yee Resident #41				
		eing "cranky" was				
	terminated in D					
	performance is	osucs.				
	On 6/20/12 at 9	9:45 a.m., the DoN				
		e-written letter, dated				
	· ·	ibing the details of				
		concerns. The letter				
	· •	ame of resident] stated				
		mber had been cranky				
		she had told [CNA				
	#3]She state					
		11 [name of resident]				
		at [name of employee]				
	was cranky wit	h her and did not				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 15E245	A. BUILDING B. WING	<u>00</u>		COMPLETED 06/21/2012
	PROVIDER OR SUPPLIER JSTINE HOME FOR THE AGED	23	REET ADDRESS, CITY, STATE, 7 45 W 86TH ST DIANAPOLIS, IN 46260	IP CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF TA	PROVIDER'S PLAN OF CEACH CORRECTIVE ACTURED TO	ION SHOULD BE THE APPROPRIATI	(X5) COMPLETION DATE
	answer her call light promptlyreviewed with [CNA #3] the importance of going to [reference to Unit Manager] immediatelyThe policy for reporting incidents was reviewed" The report indicated Resident #41 identified the employee that was "cranky" to her. The letter indicated the employee had been terminated on December 21, 2011 and had not worked since December 6, 2011. The record lacked documentation of the allegation voiced in December being investigated at that time or reported to the state survey agency. 3.1-28(e)				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E245	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2012
	PROVIDER OR SUPPLIER		STREET 2345 W	ADDRESS, CITY, STATE, ZIP CODE / 86TH ST JAPOLIS, IN 46260	·
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
F0226 SS=D	ETC POLICIES The facility must written policies a mistreatment, ne residents and mi property. Based on recor interview, the fa implement polici for allegations of investigating ar allegation of a s "cranky" to a re reporting an all misappropriation 2 of 3 incidents Findings includ 1. The record of reviewed on 06 Diagnoses includ imited to multipultionsteoporosis and The most recer Data Set [MDS 5/9/12, indicate 15 out of a pos Interview for Me scale for cogniti	acility failed to cies and procedures of abuse by not and not reporting an estaff member being esident and by not egation of on of a gold crucifix for a reviewed. (#2, #41) e: for Resident #2 was 6/19/12 at 2:37 p.m.	F0226	The Administrator will see the State is properly informed and she will seek the help of the in seeing that this is done. The Administrator, the Sister on the unit and the DON will keep a running log of each incident to occurred.	nd DON 'he he

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15E245	B. WIN	G		06/21/2	2012
NAME OF P	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
CT ALICI	JSTINE HOME FO				86TH ST APOLIS, IN 46260		
		R THE AGED		INDIAN	APOLIS, IN 40200		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		view on 6/19/12 at	+	0		<u> </u>	5.112
1		ident #2 indicated she					
	•	gold crucifix. Resident					
	#2 could not remember the exact time						
		nissing. Resident #2					
ı	indicated the crucifix was not found and it was irreplaceable.						
	A nurses note,	dated 10/18/11 at					
		licated, "Called					
	-	set. Stated she had an					
	18 carat gold n	ecklace on her					
	bookshelf at 2	p [sign for and] missing					
	by 4 p" The	note indicated charge					
	nurse notified a	and POA [power of					
	attorney] notifie	ed.					
		e progress note, dated					
		10 p.m., indicated, "This					
		n away on vacation					
		- Told by [name of Unit					
		related to] loss of this					
		klace [sign for with]					
	•	nt '18 K [carat] gold!'					
	and has had it	•					
		ccess finding necklace,					
	_	ident] had left in her					
	room on a shell						
		necklace for abt					
		our] time and went back					
		ctivities - necklace					
	gone"						
	During an inter	view on 6/19/12 at					
	_						
	_	investigation regarding					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLI	ETED
		15E245	B. WIN			06/21/2	2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹			86TH ST		
ST AUGU	JSTINE HOME FOI	R THE AGED			APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	ucifix was requested or of Nursing (DoN).					
	During an inter	view on 6/20/12 at					
	_	Unit manager indicated					
		was filed for the					
	missing crucifix						
	Thissing crucin	ν.					
	On 6/20/12 at 9	9:45 a.m., a facility					
		the Unit Manager					
		nissing crucifix, dated					
		presented by the DoN.					
	10/10/11, was	presented by the bott.					
	A type-written i	report, dated 10/18/11					
		and provided by the					
		Resident #2 reported					
		ld crucifix and chain					
		report indicated,					
		e leaves it on the book					
		never she removes it					
		when out of the room					
	1	d bathWhen she					
	returned to her						
		oticed that it was not in					
	1	on the bookcase					
		ere searched and it					
		oundrelated the					
	situation to [na						
	Administrator].						
	During an inter	view on 6/20/12 at					
	12:41 p.m., the						
		vas not aware if a					
		ad been filed or if the					
	1 -						
	state survey ag	gency had been					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15E245		LDING	00	COMPL: 06/21/	
		.00	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/2 !//	
NAME OF P	PROVIDER OR SUPPLIEF				86TH ST		
	JSTINE HOME FOR	R THE AGED			APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	`				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	SS-REFERENCED TO THE APPROPRIATE	
PREFIX TAG	notified. She in administrator widecision. During an inter 6/20/12 at 12:4 when she retur learned of the resident was as crucifix, and a offered. The Diresident and the reimbursement another country replaceable. During an inter 2:05 p.m., the with the missing cruto the police or agency. The Athere was suspicing the country of the country to the police or agency. The Athere was suspicing to the country to the country to the police or agency. The Athere was suspicing to the country to the country to the police or agency. The Athere was suspicing to the country to the country to the country to the police or agency. The Athere was suspicing to the country to t	cy MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Indicated the Yould make that view with the DoN on 5 p.m., she indicated ned from retreat and missing crucifix, the sked the value of the reimbursement was oN indicated the e POA declined the indicating it was from y and was not view on 6/20/12 at Administrator indicated icifix was not reported the state survey administrator indicated vicion a staff member, gold crucifix, and the terminated for other		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION DATE
	reviewed on 6/	for Resident #41 was 19/12 at 3:39 p.m. uded, but were not					
	limited to hype	rtension, coronary s, osteoporosis, and					
	The most recei	nt annual Minimum					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		15E245	B. WIN			06/21/	2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		2345 W	86TH ST		
ST AUGI	JSTINE HOME FOI	R THE AGED			APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	,	S) assessment, dated					
	· · · · · · · · · · · · · · · · · · ·	ed Resident #41 was a					
	-	sible 15 on the BIMS					
	scale for cognition which indicated						
	Resident #41 v	vas cognitively intact.					
	During an inter	view on 6/18/12 at					
	10:46 a.m., Re	sident #41 answered					
	"yes" when asl	ked, "Has staff yelled or					
		ou?" Resident #41					
	1	etimes during dressing					
		e CNA's were "cranky					
	_	are understaffed."					
	because they c	are understaned.					
	During an inter	view on 06/19/12 at					
	_						
		I #2 indicated Resident					
		indicated discontent					
		that worked with her.					
		ed no other resident					
	-	been voiced. LPN #2					
	indicated, "You	ı see how friendly					
	everyone is." I	LPN #2 indicated					
	Resident #41 r	eceived a bath today					
	and was on a	Tuesday and Friday					
	bath schedule.	LPN #2 indicated					
		equired assistance with					
	bathing and dr	-					
		·· J ·					
	During an inter	view on 6/19/12 at					
	_	A #3 indicated that					
	· · ·	nad indicated to her the					
	1	s do not care for her					
		ants to be cared for.					
		ted Resident #41					
	indicated the C	CNA's are "mean."					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E245	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	ie survey ipleted 21/2012
	PROVIDER OR SUPPLIER		2345 W	ADDRESS, CITY, STATE, ZII / 86TH ST APOLIS, IN 46260	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
		ed she had informed dent #41's care				
	4:04 P.m., LPN not aware of Roconcerns. She inform the DoN she became aware concern. She i recall CNA #3 sconcerning Res	indicated she would or the Unit Manager if ware of a resident care ndicated she could not sharing information sident #41.				
	4:30 p.m., the I not aware of ar voiced from Re	view on 6/19/12 at DoN indicated she was ny care concerns sident #41. She really puzzles me."				
	8:32 a.m., the I investigating th Resident #41, to voiced to CNA and the employ					
		9:45 a.m., the DoN e-written letter, dated				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIP	LE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	ì	00	COMPL	
		15E245	B. WING			06/21/	2012
NAME OF P	PROVIDER OR SUPPLIER	t			DDRESS, CITY, STATE, ZIP CODE		
OT 41101	IOTINE LIONE FOR	THE AGED			86TH ST		
STAUGU	JSTINE HOME FOR	R THE AGED	INI	JIANA	APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	j	DEFICIENCY)		DATE
		bing the details of					
		concerns. The letter					
	_	ame of resident] stated					
		mber had been cranky					
		she had told [CNA					
	#3]She stated						
	· ·	11 [name of resident]					
		at [name of employee]					
		h her and did not					
	answer her call	_					
		ewed with [CNA #3] the					
		going to [reference to					
		immediatelyThe					
		ting incidents was					
		he report indicated					
		dentified the employee					
		ky" to her. The letter					
		mployee had been					
		December 21, 2011					
		orked since December					
	6, 2011.						
	 _ ,						
		ked documentation of					
		oiced in December					
		ted at that time or					
	reported to the	state survey agency.					
		(4) 1 841					
	A facility policy						
	Prohibition, Re						
		f Resident Abuse,					
		streatment, dated					
	· ·	ovided by the DoN on					
		a.m., indicated,					
	1	entis entitled to					
	respectful, cou	rteous treatment. The					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	00	(X3) DATE SURVEY COMPLETED
ANDILAN	15E245	A. BUILDING		06/21/2012
	102270	B. WING	ADDRESS CITY OF THE CORE	30/2 1/20 12
NAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE ' 86TH ST	
ST AUGI	JSTINE HOME FOR THE AGED		APOLIS, IN 46260	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	Facility will not tolerate rude,			
	threatening or abusive behavior			
	toward a Resident or any other			
	mistreatment of a Resident. For			
	purposes of this policy, 'mistreatment'			
	includes the misappropriation of			
	Resident's property1. All of the			
	following are examples of possible			
	abuse, neglect or mistreatment and			
	must be reported immediately to the			
	Unit Supervisor and charge nursec.			
	Verbal abuse, including rude,			
	disrespectful or threatening			
	languagee. Missing Resident			
	property6. As soon as possible, but			
	within no more that twenty-four (24)			
	hours of the suspected abusethe			
	Administrator shall notify the Office of			
	Health Care Quality and the local			
	policy (sic) department7. The			
	Administratorshall conduct an			
	investigation and report all results below" The DoN indicated the			
	Office of Health Care Quality would			
	be the state agency.			
	3.1-28(a)			
	σ. ι 20(α)			

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